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Endocrinology QUESTIONNAIRE
☎ 973-579-6300
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PATIENT HISTORY

(for all new patients)

Date: _____

Name: _____ **Age:** _____ **Sex:** Male Female

Who is filling out this form/relationship to patient? _____

Why were you referred for an endocrinology consult? _____

Who referred you? _____

When did your symptoms start? _____

Current or previous treatment for the problem: _____

Past Medical History – check those that apply:

- | | | |
|---------------------------------------------------------|---------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Calcium Disorder | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Broken Bones? Which? |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Adrenal Disorder | <input type="checkbox"/> Cancer? What Type? |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pituitary Disorder | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disorder | |
| <input type="checkbox"/> Other endocrine problem, What? | | |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Other problems? | |

Past Surgeries:

Type of surgery	When?	Type of surgery	When?

Social History:

Have you ever smoked? _____ How many packs per day? _____ When did you stop? _____
 How much alcohol do you drink? _____ When did you stop? _____
 Have you ever used recreational drugs? _____ When did you stop? _____
 What kind of work do you do? _____

Who do you live with?

Do have children?

Biological children?

How many?

Have you been vaccinated for?

___Influenza

___Pneumonia

Family History: *Please check when applicable. Check here ___ if family history is unknown*

	Mother	Father	Sister(s)	Brother(s)	Grandparents	Other information
Heart Disease						
Hypertension						
Diabetes						
Cholesterol						
Hereditary						
Thyroid						
Cancer						
Other disease?						

Medications: *Please write down ALL your medications or provide the nurse with a complete list.*

Name and strength	How often?	Name and strength	How often?
1		6	
2		7	
3		8	
4		9	
5		10	

Allergies:

Drug

What happened?

Side effects?

Do you take?

___ Aspirin	___ Multivitamins	___ Calcium, ___ Vitamin-D, How much?
___ Herbs, What?	___ Alternative medicine, What?	

How would rate your physical activity? Mild, Moderate, Active, or Very active (circle one)

How much did you weigh a year ago? _____

Review of Systems: *Please check all that apply.*

- | | |
|----------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Fatigue or weakness? | <input type="checkbox"/> Rash? |
| <input type="checkbox"/> Recent fever? | <input type="checkbox"/> Skin lesions? |
| <input type="checkbox"/> Weight gain? Amount? _____ | <input type="checkbox"/> Pigment change? |
| <input type="checkbox"/> Weight loss? Amount? _____ | <input type="checkbox"/> Hair loss? |
| <input type="checkbox"/> Blurred vision? | <input type="checkbox"/> Nail changes? |
| <input type="checkbox"/> Vision loss? | <input type="checkbox"/> Headache? |
| <input type="checkbox"/> Eye pain? | <input type="checkbox"/> Seizure? |
| <input type="checkbox"/> Tooth pain? | <input type="checkbox"/> Dizziness? |
| <input type="checkbox"/> Voice change? | <input type="checkbox"/> Double vision? |
| <input type="checkbox"/> Hearing loss? | <input type="checkbox"/> Tremors? |
| <input type="checkbox"/> Ringing in ears? | <input type="checkbox"/> Paralysis? |
| <input type="checkbox"/> Chest pain? | <input type="checkbox"/> Recent numbness or tingling? |
| <input type="checkbox"/> Palpitations or irregular heartbeats? | <input type="checkbox"/> Loss of conscience or fainting spells? |
| <input type="checkbox"/> Edema? | <input type="checkbox"/> Depression? |
| <input type="checkbox"/> Shortness of breath? | <input type="checkbox"/> Anxiety? |
| <input type="checkbox"/> Pain in legs after walking? | <input type="checkbox"/> Positive psychiatric history? |
| <input type="checkbox"/> Recent increase of cough? | <input type="checkbox"/> Kidney stones? |
| <input type="checkbox"/> Wheezing? | <input type="checkbox"/> Cold intolerance? |
| <input type="checkbox"/> Abdominal pain? | <input type="checkbox"/> Heat intolerance? |
| <input type="checkbox"/> Recent nausea? | <input type="checkbox"/> Excessive drinking of fluids? |
| <input type="checkbox"/> Recent vomiting? | <input type="checkbox"/> Constant hunger? |
| <input type="checkbox"/> Recent diarrhea? | <input type="checkbox"/> Goiter? |
| <input type="checkbox"/> Recent constipation? | <input type="checkbox"/> General weakness? |
| <input type="checkbox"/> Loss of appetite? | <input type="checkbox"/> Goiter or neck lump? |
| <input type="checkbox"/> Difficulty with or pain on swallowing? | <input type="checkbox"/> Recent increase in shoe size or ring size? |
| <input type="checkbox"/> Heartburn or indigestion? | <input type="checkbox"/> Loss of libido? |
| <input type="checkbox"/> Increased or frequent or painful urination? | <input type="checkbox"/> Anemia or low blood? |
| <input type="checkbox"/> Frequent urination at night? | <input type="checkbox"/> Easy bruising or bleeding? |
| <input type="checkbox"/> Accidents with urine? | <input type="checkbox"/> Hot flashes? |
| <input type="checkbox"/> Sexual dysfunction? | <i>For Women only:</i> |
| <input type="checkbox"/> Joint pain? | <input type="checkbox"/> Increased body hair? |
| <input type="checkbox"/> Back pain? | <input type="checkbox"/> Irregular menstrual periods? |
| <input type="checkbox"/> Muscle cramps or muscle weakness? | <input type="checkbox"/> Breast discharge? |

GYN History: *For Women only*

- | | | |
|------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Number of pregnancies | <input type="checkbox"/> Age that you first delivered | <input type="checkbox"/> Last period _____ |
| <input type="checkbox"/> Number of deliveries | <input type="checkbox"/> Did you ever use hormones? | <input type="checkbox"/> Bleeding other than periods? |
| <input type="checkbox"/> Age of first period | <input type="checkbox"/> Birth control pills? | <input type="checkbox"/> Did you breast feed? |